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FEATURED EXPERT

An Interview with Rebekah Fenton MD, MPH, FAAP

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Q: Your work centers the needs of historically marginalized youth populations, which are underrepresented in eating disorder treatment and research settings. Could you elaborate on the specific challenges the patients you serve face with disordered eating and body dissatisfaction. How do you address these needs as a pediatrician?

A: Whenever medicine perpetuates a specific idea of who a condition affects, patients from marginalized groups who do not fit that stereotype are less likely to be diagnosed and receive treatment. The stereotypical eating disorder patient is a thin, white female adolescent with a perfectionist personality, straight As, and high socioeconomic status. This stereotype excludes the fact that eating disorders touch every age, race, ethnicity, gender, sexual orientation, weight, and disability status. Patients who identify outside of that stereotype are less likely to be recognized as having an eating disorder despite meeting criteria and experiencing complications of their condition. Eating disorder therapy includes not just medical care, but also therapy services. These programs are often exclusively for patients with private insurance excluding marginalized groups that make up the majority of patients with Medicaid. This inaccessibility makes it more challenging for patients to receive the specialized and evidence-based care they need.

Body dissatisfaction can also look different for patients depending on the communities they are a part of and who sets the standard for beauty. For example, some thin patients may report body image issues if the beauty standard within their community includes curvy features, like a bigger butt and thighs. Jason Nagata, an adolescent medicine researcher at Stanford, has done a lot of work to show how eating disorders are also prevalent in boys and LGBTQ+ youth.

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These are just a couple of examples of how diverse the presentation of eating disorders can be and a reminder that patients should be assessed based on their history, vitals, and physical exam, not their appearance.

Q: Could you share more about your motivation to pursue adolescent medicine, and how you became interested in the area of weight-stigma in the health of children and adolescents?

A: I decided in high school that I wanted to work with adolescents after seeing the challenges my classmates struggled with. I remember one friend announcing her plan to skip lunch for a week in preparation for Homecoming. My friends did not say anything back and even more surprising, this announcement was made right after an assembly about eating disorders. There was clearly a disconnect between the information we were taught and our behaviors. I realized my own pediatrician never asked me about my eating habits and did not screen me for the early signs of an eating disorder. These experiences helped me see that adolescence is a unique time period where issues are often left unaddressed because the right questions are not being asked. I considered various fields working with teenagers, social work, psychology, education, etc., but ultimately decided medicine gave me the fullest picture of an adolescent's health because I can understand the inner workings of the body and have an appreciation for the psychosocial factors that shape health.

My interest in the management of weight concerns started with eating disorders as well as my own experiences living in a body at a higher weight. Growing up, my only health problem was my weight, which I gained over the course of high school due to a lack of regular physical activity. I was so focused on taking as many AP classes as I could that I took PE over the summer so I could have one extra period at school. I did not notice these changes until I had to buy new uniform skirts because I outgrew the others. I am grateful my pediatrician never shamed me for these changes, especially after learning about the lifelong impact weight stigma can have. My first experiences of weight stigma were in college and they still had a profound impact on me, causing me to avoid primary care visits for years. My personal experiences and those of my family led me to want to approach the topic of weight sensitively to avoid causing the same harm I experienced. Yet, a patient encounter in residency made me realize that focusing on weight at all, not just how I approached it, was the problem. That experience made me want to learn a better way and share it so others can avoid perpetuating similar harm.

Q: Your advocacy involves addressing health inequities among historically minoritized patients. Do you think recently released American Academy of Pediatrics guidelines on treating "obesity" in children and adolescents addresses these inequities sufficiently?

A: I greatly appreciate that the AAP obesity guidelines acknowledge the tension of seeing obesity as a problem in an inequitable world where Black and Brown children are more likely to be obese because of systemic oppression and community disinvestment. It was also clear the writers struggled to ask families to manage obesity when they have inequitable access to nutrition, safe play spaces, and programs that can support children in achieving lower BMIs. Where I feel like the guidelines don't sufficiently address the needs of minoritized groups is that they 1) recognize obesity as a chronic status, but still consider it a disease that needs to be managed and 2) they don't acknowledge the diversity of bodies as normal, especially in minoritized groups where higher weights may not necessarily mean poor health status.

Q: The AAP guidelines recommend early and aggressive treatment of "obesity" in youth including Intensive health behavior and lifestyle treatment (IHBLT), weight loss medications and bariatric surgery. What are your thoughts about these interventions and do your patients have access to them?

A: I have two conflicts with the recommendations for early and aggressive treatment of obesity. First, it frames weight management/loss as a necessary component of managing weight-related conditions by encouraging pediatricians to treat it concurrently with any comorbidities. It assumes the connection between health and weight is causal and that improved health requires weight loss. In reality, metabolism, rather than weight, has a huge impact on health status, which is why I prefer the term nutrition-sensitive conditions to weight-related comorbidities. I've had pediatric obesity physicians confirm that by changing nutrition and physical activity habits, they see resolution of patients' diabetes and other metabolic disorders before they even lose weight. This clinical phenomenon led me to question if weight loss is even necessary, especially given the high risk of relapse.

My second conflict is the inaccessibility of these services. The authors of the AAP guidelines acknowledge that not every patient can access IHBLT due to insurance and limited program availability. Weight loss medications can be inaccessible or require lengthy prior authorizations to prescribe for patients with public insurance. For those who can access medications, the guidelines may also lead to over-reliance on prescriptions because they are more accessible than behavioral and lifestyle treatment, despite recommendations that counseling should be first-line and alongside medications. I am also concerned that bariatric surgery, while an effective form of weight loss, has long term lifestyle consequences that adolescents and their families may not fully understand.

Prior to these guidelines being released, the demand for obesity medicine referrals was much higher than the availability. The authors acknowledged this gap and hoped their guidelines would promote greater advocacy for their expansion and accessibility. Yet, this article is a practice guideline and therefore is designed to be used now, leaving many families and providers stuck between feeling the need to fix obesity as a problem and without the means to do so. They recommend every child with obesity should receive services that simply do not exist or cannot be easily accessed to meet that demand.

Q: You've written extensively about health equity. What, in your opinion, are the key steps needed to achieve equitable healthcare for all, especially for Black youth?

A. Within healthcare, the largest determinant of the quality of care adolescents receive is insurance status. Patients who are uninsured or have public insurance have less or no options for various services from hospitals they can be referred to for specialty care to therapy services and programs. Black and Brown youth make up a greater proportion of the Medicaid population than white youth and therefore have less access to the care services they need. I experience a great deal of stress just weighing options for the best way to support my current patient population who predominantly have Medicaid. A single-payer system would eliminate these concerns.

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Achieving health equity also requires dismantling racism to promote Black liberation. It looks like removing barriers to healthcare by diversifying the workforce and training healthcare providers to practice anti-racism. It also means addressing the systemic factors that make Black youth in particular more vulnerable to health problems. Healthcare only makes up 20% of a community's health, while social, economic, and environmental factors make up 50% combined. Therefore, to achieve equitable healthcare, we would also need to recreate a world where no child or their family are unable to access the resources they need to thrive: housing, clean water, safe streets, parks, community services, accessible grocery stores, quality transportation, etc.

Q: Winning the James Owens Sr., MD, Award for Excellence in Adolescent Health and Medicine must have been an honor. How do you think such recognition helps to amplify your voice as a pediatric expert and elevate the causes you advocate for in healthcare?

A: I was honored to be recognized for my clinical skills in adolescent medicine during my residency program. It confirmed my passion for and skills in adolescent health. It also reflected how my peers then and now look towards my communication skills with adolescents as aspirational. My attendings often called me the "teen whisperer" because of my ability to connect with adolescents, no matter how closed off they initially seemed. Yet, my advocacy voice grew out of a feeling that resident voices were being underestimated in physician advocacy. I was a part of my program's advocacy track and while I loved receiving training in media-based advocacy, there were few opportunities to practice it as a resident. It made me feel like I could only be seen as an expert once I finished training and became an attending; I wanted to refute that sentiment. From residency through fellowship, I engaged in writing op-eds, speaking at conferences and community programs, and posting on Twitter to spread messages about health equity, health communication, and adolescent health in order to prove to myself and others that the voices of medical trainees matter and should be recognized as expertise. I am very proud of what I have been able to accomplish. I love seeing how my work has inspired other trainees to own their voices and practice their advocacy skills.

Q: Could you discuss the impact of weight stigma on adolescents, particularly in the age of social media?

A: Weight stigma has a profound impact on adolescents. It can have physical and emotional ramifications. Roberts et al. in their article "Weight stigma in children and adolescents: Recommendations for practice and policy" defined weight stigma as social devaluation and denigration of a person because of their excess body weight. In my screening for weight-related concerns with adolescents, I hear experiences of weight stigma involving peers, family, and healthcare providers. Teenagers describe being teased by classmates and not receiving support or protection from school administration when they report it. They also describe hearing comments from parents and other family members or feeling pressure to lose weight because of their primary care provider.

These experiences can easily become internalized and lead to low self-esteem, anxiety, and depression or cause adolescents to engage in disordered eating. They can also impact an adolescent's engagement in school or social activities. Research has repeatedly shown that shaming patients does not cause them to lose weight. Weight stigma worsens physical health by leading to weight gain, increased metabolic risk, and decreased physical activity.

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Social media promotes weight stigma by portraying idealized and often unrealistic body ideals like thigh gaps or edited photos to make adolescents feel like their bodies are wrong. At the same time, social media can also combat weight stigma by showing and celebrating diverse bodies, which is why discussions with patients about social media use and teaching them to cultivate positive feeds can have a tremendous impact on a patient's self-image.

Q: Many people in the eating disorder field have written about systemic racism in weight standards and BMI itself, as these "standards" have been almost exclusively centered on white bodies. Would you say that youth of color are disproportionately harmed by these standards? What are better measures of health that take cultural norms and needs into account?

A: The history of BMI calculations is really fascinating and surprisingly not addressed at all in medical education about obesity. I only learned about it by reading texts outside of medicine. The BMI equation was created by a mathematician and sociologist to describe the ideal body type. Insurance companies used the calculation among its predominantly white male clients to determine who was perceived to be at higher risk of health complications and premature death. These early foundations of BMI, which were later applied to other racial groups and then arbitrarily changed to increase the number of people considered obese, lead to false assumptions that everyone at higher weights is at risk of certain health conditions regardless of factors like race and muscle mass. For children, the cut-offs for overweight and obesity were even more arbitrary and lead children and their families to think weight is a problem that needs to be addressed. When 25% of Black children and 26% of Hispanic children are obese compared to 16% of white children, then obesity seems more like a proxy for systemic racism and its impact on social determinants of health than a measure of health. There are some in the obesity medicine space who advocate for body fat measurements as a better measure for those at risk of nutrition-sensitive conditions. I personally prefer to just screen for metabolic conditions, like diabetes and high cholesterol, based on age, eating habits, and family history, rather than weight.

Q: How do you navigate discussions with adolescents about body image, eating and movement? How as a pediatrician did you learn about this?

A: My approach has completely changed over the course of my training. I was initially taught to focus on "growth chart, growth chart, growth chart", to explain what it means, where a child falls along it, and tailor my counseling based on their BMI percentile. For higher weights, I would emphasize the development of healthy habits and skip over that discussion for children with average weights. Now, I try to help patients separate the concepts of weight and health by acknowledging that weight is often not something they can control and not a reflection of their health. If they still have ideas about what their weight should be or concerns about their weight as it is, we talk about them as insecurities, not medical problems. Then, for every patient, I facilitate a discussion about building a long-term healthy

lifestyle focused on eating a balanced diet that still includes the snacks and sweets they enjoy and regular physical movement doing activities they genuinely like. I was inspired by reading several books about weight stigma and obesity, then I developed my own method of supporting patients and use social media as a way to educate other providers.

Q. Given how deeply ingrained in medical training that weight stigma and the "thin equals healthy" myth are, it's remarkable and refreshing that you practice weight neutral care. At what point in your career did you learn about HAES and weight neutral medicine? Has it made a difference to those you care for?

A: I was motivated to learn a different way after feeling like my approach was failing patients. Around that time, a dietician who I worked with at my resident clinic shared what she learned about Health at Every Size (HAES) at a recent conference. Her presentation in 2017 was the first time I ever heard of an alternate way to address weight/body size. Starting with the book she recommended, "The Body is Not an Apology" by Sonya Renee Taylor, I continued my research and tried different communication techniques until I found an approach that feels accurate and destigmatizing. I also believe learning is lifelong and I am still refining what I say and do to keep up with existing research and patient needs.

I decided to call my practice weight-neutral medicine about a year ago to describe the fact that I don't focus on the number when my patients step on a scale. I'll tell them, "I care about you and your health, but I don't actually care about your weight." It also means that I don't associate value to a particular number. Weight is still an important vital sign in adolescence because changes in either direction can indicate a health problem. When I see weight loss, for example, I don't automatically praise a patient or congratulate them. Instead, I ask questions to better understand their motivations and efforts that led to that change. I think patients seem less burdened by our conversations and empowered to implement healthy habits without the pressure of weight loss weighing on them. They also sometimes feel confused to hear a doctor share a message that drastically differs from other healthcare experiences and societal standards. Sometimes, it takes multiple conversations to help them realize there is a better and healthier way to view their bodies.